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A newsletter for GEORGIA BETTER HEALTH CARE providers

Volume 2 Issue 3

GBHC Member Auto Assignment Update

Georgia Better Health Care (GBHC) utilizes an automated process to assign eligible Medicaid and PeachCare for Kids members to GBHC primary care physicians (PCPs). The criteria for this assignment include a member's (or family member's) previous history with a PCP, gender, age, and geographic proximity. Members are notified of the PCP assignment, but are also given a list of providers within their service area if they wish to select a different PCP. Members may request a PCP change within the first 90 days of enrollment (or initial PCP assignment) and up to every six months thereafter.

The Department of Community Health contracts with primary care physicians who agree to:

·Offer and coordinate all health care services (including referrals for necessary specialty services).

·Maintain 24-hour availability to members.

·Be available in the office to provide general medical care for a minimum of 30 hours per week for primary care services.

Primary care physicians receive a monthly case management fee of $2.00 per member per month for coordinating members' health care services, whether or not they see the member that month. When services are provided, providers are reimbursed on a fee-for-service basis according to the regular Medicaid fee schedule.

Many GBHC providers have had questions related to what appears to be the loss of members or the gaining of new members who were not previously assigned to their practice. Under the current system, a provider may notify GBHC, in writing, of his decision to close his practice to the assignment of new members and therefore become an Established Patients Only (EPO) provider. This does not prohibit members assigned to an EPO practice who lose and then regain Medicaid eligibility from being reassigned to that EPO provider.

The system will look at an EPO relationship and the related claims history and reassign that member to the EPO practice. This is an enhancement to our new system in response to EPO provider complaints regarding the loss of long-standing members by an EPO practice.

During auto-assignment, the system looks at all claims history to identify a claims relationship that will validate an assignment. For this purpose, a case management fee paid to a provider is considered a claim history. The provider receives this case management fee regardless of whether or not the member is treated by the practice, and is therefore responsible for coordinating the medical care of all assigned members. The presence of a prior EPO relationship will override claims with another provider and that member will be reassigned to the EPO practice.

The verification of member eligibility is the responsibility of the provider. Neither the appearance of a member's name on the roster nor the possession of a Medicaid card guarantees eligibility or the assignment to a specific PCP. The provider should verify eligibility via the Web Portal, the IVR, or by speaking to a customer service representative at the CIC.

Auto Assignment Statistic for the month of November

Over 330,000 members were auto assigned on October 24, 2003 for the month of November.

The last auto assignment occurred November 5, 2003 for the month of December. All future assignments will run at the beginning of each month and members will be will auto assigned for the next month.

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GBHC Referral Process

Effective April 1, 2003, the Georgia Better Health Care (GBHC) referral process changed. The new process generates a unique 12-digit referral number, which is valid for up to 90 days. When the change went into effect, DCH encouraged GBHC providers to use the new referral process, but also accepted referral information submitted through the old authorization method. The change was applicable to those Medicaid or PeachCare for Kids members who participate in GBHC.

Effective October 1, 2003, the new GBHC referral process became the only method to obtain referrals. For dates of services after October 1, 2003, providers must have a new, 12-digit referral number. The old GBHC Authorization numbers are no longer accepted for any dates of service after this date.

A referral generated by a primary care physician (PCP) is valid for 90 days, or for the number of visits, which ever comes first. If a specialist is unable to schedule the patient within 90 days, the specialist should contact the referring PCP and request a new referral as the appointment time approaches. If more patient visits are required beyond the initial referral authorized by the PCP, the specialist is responsible for requesting another referral from the PCP.

GBHC Providers – Patient Panel Size

GBHC providers may choose to limit their patient panel size by changing their status to Established Patients Only (EPO). By doing this, providers will not have new GBHC or PeachCare members assigned to their practices. GBHC - EPO providers will continue to have their established patient reassigned to their practice should the member lose and then regain Medicaid eligibility. Providers choosing to become EPO should contact Provider Enrollment and make the request in writing at:

GHP
P.O. Box 5000
McRae, GA 31055

Or by facsimile at:
1-866-483-1044 or 1-866-483-1045.

EPO providers may choose to add new patients, by using the GBHC/PeachCare Provider Selection form located in the GBHC Provider Manual. New members will not be assigned to an EPO provider without that provider's authorization. Those members, regardless of the patient/provider relationship, will not be assigned to an EPO provider unless a GBHC/PeachCare Provider Selection Form is submitted to GHP.

PCPs must specify the number of members they wish to serve. Maximum enrollment for individual physicians is 1200 members. Nurse practitioners or physician assistants may enroll up to 600 members. Maximum enrollment limits for group practices are based on the number of physician full-time equivalents (FTEs) multiplied by 1200, and nurse practitioner or physician assistant FTEs multiplied by 600. GBHC makes no implicit or explicit guarantee of member enrollment numbers. Physicians who wish to enroll greater than the maximum allowed may submit a written request to GHP at:

GHP
P.O. Box 5000
McRae, GA 31055

Or by facsimile at:
1-866-483-1044 or 1-866-483-1045

Providers may also choose to establish member composition by Gender (male only, female only or both) or Age Range under the areas of Pediatrics (ages 0 < 19 or ages 0 < 22), Family Practice (ages 0 – 99 or ages 2 – 99), Adult only (> 14 years of age), or Gynecology (> 14 years of age). Requests for changes to member composition should be directed to Provider Enrollment and make the request in writing at:

GHP
P.O. Box 88030
Atlanta, GA 30356

Or by facsimile at:
1-866-483-1044 or 1-866-483-1045.

GBHC Referral Process Update

In an effort to provide greater authority to the PCP, under GBHC and the PCP's reimbursed case management responsibilities, effective April 1, the GBHC Referral process changed. GBHC PCP's are responsible for entering a referral into the GHP system, therefore providing authorization for another medical specialist to treat a GBHC member. Referrals will be electronic and can be generated via the web portal, interactive voice response (IVR) system, by contacting the customer interaction center (CIC), or via fax or email. Medical specialists will be able to retrieve the referral number (which is specific to the member and by type of service) via the web portal, IVR, or by contacting the customer interaction center.

Referrals will be required when a GBHC PCP refers a member to:

- A specialist for evaluation and/or medical care;
- A provider who is "covering" for the PCP during periods of absence from the PCP setting (such as weekend coverage when the PCP is not in town); or
- A Health Check provider for a Health Check screening.

Referrals will fall in one of three categories:

- Evaluation (1 visit)
- Evaluation and Treatment (3 visits)
- Health Check (4 visits)

Referrals will not be required for ancillary services, diagnostic testing, DME, home health or hospitalizations. The ordering provider will be responsible for obtaining any necessary Prior Authorizations or Preadmission Certifications. The ordering provider, if not the PCP, must have a valid referral from the PCP prior to receiving prior authorization for additional visits or precertification for elective admissions. The referral should be prior to services rendered.

All providers in the PCP group billing under the same Tax ID number may see their own GBHC members at any of their practice locations without a referral. All providers in a specialty group billing under the same Tax ID number may see a GBHC member at any of their practice locations with a single referral (subject to the service limits of the referral).

Referrals are valid for 90 days from the effective date or by the number of visits, whichever comes first. The effective date is either the date the referral is entered, or it may be backdated up to 30 days to accommodate for coverage situations.

The following services continue to be exempted from PCP referral requirements: Anesthesiology, Children's Intervention, Community Care, Dental (excluding Oral Surgery), Dialysis, Early Intervention Case Management, Family Planning, Health Department, Hospice, Independent Care, Independent Laboratory, Non-Emergency Transportation, Nursing Home, ICF/MR, Swing Bed, Optometry (including Eye Glasses), Pathology, Pharmacy, Podiatry, Pregnancy Related, Psychology & Other Mental Health, Targeted Case Management, Therapeutic Residential Intervention and Wavered Home Care.

HealthCheck Diagnostic Services Exempt From GBHC Referral Requirements

Current PROC CODE **Until 12/31/03**	*Current Diagnosis CODE* **Until 9/30/03**	*HIPAA PROC CODE* **As of 1/1/04**	*HIPAA MODIFIER* As of 1/1/04	*PROCEDURE CODE DESCRIPTION*	*Diagnosis CODE*
YN880	**N01**	**99173**	**EP**	INTERPERIODIC VISION (NORMAL)	V72.0
YR880	**ICD-9 Code for identified problem**	**99173**	**EP**	INTERPERIODIC VISION (ABNORMAL)	The appropriate ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) diagnosis code.
YN882	**N01**	**V5008**	**EP**	INTERPERIODIC HEARING (NORMAL)	V72.1
YN882	**N01**	**92551**	**EP**	INTERPERIODIC HEARING (NORMAL) **screening both ears, pure tone, air only*	V72.1
YN882	**N01**	**92552**	**EP**	INTERPERIODIC HEARING (NORMAL) **screening both ears, pure tone audiometry (threshold); air only*	V72.1
YN882	**N01**	**92553**	**EP**	INTERPERIODIC HEARING (NORMAL) **screening both ears, pure tone audiometry (threshold); air and bone*	V72.1
YN882	**N01**	**92555**	**EP**	INTERPERIODIC HEARING (NORMAL) **screening both ears, speech audiometry threshold*	V72.1
YN882	**N01**	**92556**	**EP**	INTERPERIODIC HEARING (NORMAL) **screening both ears, speech audiometry threshold with speech recognition*	V72.1
YR882	**ICD-9 Code for identified problem**	**V5008**	**EP**	INTERPERIODIC HEARING (ABNORMAL)	The appropriate ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) diagnosis code.
YR882	**ICD-9 Code for identified problem**	**92551**	**EP**	INTERPERIODIC HEARING (ABNORMAL) **screening both ears, pure tone, air only*	The appropriate ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) diagnosis code.
YR882	**ICD-9 Code for identified problem**	**92552**	**EP**	INTERPERIODIC HEARING (ABNORMAL) **screening both ears, pure tone audiometry (threshold); air only*	The appropriate ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) diagnosis code.
YR882	**ICD-9 Code for identified problem**	**92553**	**EP**	INTERPERIODIC HEARING (ABNORMAL) **screening both ears, pure tone audiometry (threshold); air and bone*	The appropriate ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) diagnosis code.
YR882	**ICD-9 Code for identified problem**	**92555**	**EP**	INTERPERIODIC HEARING (ABNORMAL) **screening both ears, speech audiometry threshold*	The appropriate ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) diagnosis code.
YR882	**ICD-9 Code for identified problem**	**92556**	**EP**	INTERPERIODIC HEARING (ABNORMAL) **screening both ears, speech audiometry threshold with speech recognition*	The appropriate ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) diagnosis code.

Current PROC CODE **Until 12/31/03**	*HIPAA PROC CODE* **As of 1/1/04**	*HIPAA MODIFIER* As of 1/1/04	*PROCEDURE CODE DESCRIPTION*	*Diagnosis CODE*
90647	**90647**	**EP**	HIB	V0381
90655	**90655**	**EP**	Influenza (preservative free)	V048
90657	**90657**	**EP**	Influenza ages 0 - 36 months (split virus)	V048
90658	**90658**	**EP**	Influenza ages three (3) through twenty one (21) (split virus)	V048
90659	**90659**	**EP**	Influenza ages twelve (12) through twenty one (21) (whole virus)	V048
90669	**90669**	**EP**	(prevnar) Pneumococcal Conjugate	V0382
90700	**90700**	**EP**	DTAP	V061
90702	**90702**	**EP**	DT	V065
90707	**90707**	**EP**	MMR	V064
90713	**90713**	**EP**	IPV	V040
90716	**90716**	**EP**	Varicella	V054
90718	**90718**	**EP**	TD	V065
90723	**90723**	**EP**	(DTAP, Hep B, and IPV)	V068
90732	**90732**	**EP**	Pneumococcal Polysaccharide	V0382
90744	**90744**	**EP**	Hepatitis B	V053
90748	**90748**	**EP**	Combination HEP B and HIB	V068
86580	**86580**	**EP**	TB Skin Test	V741
36415	**36415**	**EP**	Blood Lead Test	V825
	99381-99385	**EP**	Interperiodic Screen	V70.3
	99391-99395	**EP**	Interperiodic Screen	V70.3

GBHC Roundup

GBHC and PeachCare Member Rosters now available electronically

Providers have a choice in how to receive their monthly GBHC and PeachCare member rosters. Your office may designate to receive your monthly roster electronically or in hard-copy format. The Department is encouraging all providers to utilize the electronic format to reduce the incidence of lost or misplaced rosters as well as to avoid possible problems associated with mail delivery. Member rosters will continue to show all new members, current members; and members whose relationship with the PCP has been terminated.

The member roster does not guarantee member eligibility. Providers should access the Web portal, IVR or contact the Customer Interaction Center to verify member eligibility and PCP assignment.

GBHC Enrollment Process

Medicaid providers interested in enrolling as a PCP in the GBHC program must complete a GBHC Application Addendum, an Attestation Statement, and an After-Hours Telephone Coverage and Provider Accessibility Agreement. Providers who are enrolling in GBHC as a group must complete a single Application Addendum and After-Hours Telephone Coverage and Provider Accessibility Agreement. Following receipt of a complete application packet, GHP will forward the file to GBHC Operations for verification and to conduct a site visit by a GBHC Provider Relations Field Representative. A provider's application will not be deemed complete until all steps are complete. Providers submitting "complete" applications may expect a determination within 90 days, or at a maximum by 180 days of receipt of the application by GHP. Failure to answer all questions and submit all required documents may result in return of the application and delay in the application process.

Further information related to this process and contact information can be found in Section 603 - Application Process of the Part II Policies and Procedures for Georgia Better Health Care Services.

Member Eligibility

Member eligibility with the Division of Medical Assistance is a fluid process that is updated on a nightly basis. It is the responsibility of the provider to verify eligibility prior to rendering services. Member eligibility and verification of PCP assignment can be made via the web portal, IVR or by contacting the Customer Interaction Center. A member appearing on a provider's roster or presenting with a Medicaid card and listing a PCP do not meet eligibility verification guidelines.

When a member gains Medicaid eligibility and meets the established GBHC criteria, the member is placed in auto-assignment and assigned to a GBHC provider. Requests by the member for PCP change should be made by the 15th of the month to be in effect for the coming month. Assignment requests made after the 15th will be effective to that provider on the first of the following month.

Newly eligible member cards and GBHC/PeachCare rosters are printed during the last week of the month and mailed to the members and providers respectively.

Should a member lose eligibility after this process, that change will be reflected in the system but will not appear on the card or roster. Again, the provider has the responsibility for verifying member eligibility for that date of service.

PCP assignment or selection as it appears on the member card and/or provider roster are not guarantees of Medicaid eligibility.

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Need to know definitions

Enrollee: A Medicaid recipient who is currently enrolled in a PCCM managed care program. Also referred to as a "member".

Potential Enrollee: A Medicaid recipient who is subject to mandatory enrollment who is not yet an enrollee (member) in a specific PCCM.

Health Care Professional: A physician, podiatrist, optometrist, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed clinical social worker, registered respiratory therapist, and certified respiratory therapy technician.

PCP: Primary Care Provider

PCCM: Primary Care Case Manager. A physician, a physician group practice, or an entity that employs or arranges with physicians to furnish primary care case management services that may include the following:
1. A physician assistant,
2. A nurse practitioner,
3. A certified nurse midwife.

Primary Care: All health services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, OB/GYN, or pediatrician, to the extent the provision of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Case Management: A system under which a PCCM contracts with the State of Georgia to furnish case management services (which include the locations, coordination and monitoring of primary health care services) to Medicaid recipients.

Cold-Call Marketing: Any unsolicited personal contact by the PCCM with a potential member (enrollee) for the purposes of marketing.
Marketing: Any communication to a Medicaid recipient who is not enrolled with a PCCM than can reasonably be interpreted as intended to influence the recipient to enroll with that particular provider, or to not enroll with or to disenroll from another provider.

Patient: GBHC views a member to be a provider's patient based on that provider receiving a monthly case management fee for that member, regardless of that member seeing or not seeing that provider.

Based on receipt of the case management fee, that provider is responsible for all primary care case management, including referrals, for that member.

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